Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935
1400 E. Washington Avenue
Madison, WI 53703
FAX #: (608) 261-7083
E-Mail: web@drl.state.wi.us
Phone #: (608) 266-2112
Website: http://www.drl.state.wi.us

MEDICAL EDUCATION VERIFICATION FORM

MEDICAL EXAMINING BOARD

(Not necessary if utilizing FCVS)

IMPORTANT: *PLEASE FORWARD THIS FORM TO YOUR MEDICAL SCHOOL*

The **State of Wisconsin** requests that you complete this form concerning the following individual:

APPLICANT'S NAME: _____ Soc. Sec. #*_____

MEDICAL SCHOOL: _____

MEDICAL SCHOOL ADDRESS: _____

		YES	NO
1.	Did this physician attend the medical school noted above?	☐	☐
2.	What were the applicant's dates of enrollment in this medical school? _____		
3.	Did this physician graduate from this medical school? If no, please attach explanation on a separate sheet.	☐	☐
	Degree Granted _____		
	Date Degree Granted _____		
4.	Did this individual take a leave of absence during his/her attendance at this medical school? If yes, please attach explanation on a separate sheet.	☐	☐
5.	Did this individual have a record of unexcused absences during his/her attendance at this medical school?	☐	☐
6.	Was this individual ever disciplined or under investigation during his/her attendance at this medical school? If yes, please attach explanation on a separate sheet.	☐	☐
7.	Were any special requirements imposed on this individual that were not required of all other students at his/her level of education? If yes, please attach explanation on a separate sheet.	☐	☐
8.	Was this individual recommended for post-graduate training?	☐	☐

Print name of Dean _____

Signature of Dean _____

Date form was completed _____

*For use in school locating your records

SEAL OF MEDICAL SCHOOL

Please return directly to:

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

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